Module 13:
Claims & Appeals

Module Objectives

After this module, you should be able to:

- Explain who can file claims and where claims should be submitted
- Describe how to resolve claims issues
- Distinguish between what can and cannot be appealed

Claim Basics

- Claims are filed to issue payment for services or supplies provided by civilian sources of medical care
- The person who submits the claim is either the provider of services, supplies, or the beneficiary
- The beneficiary is ultimately responsible for making sure claims are filed

Submitting Claims

- Claims are submitted to the claims processing contractor responsible for the region where the beneficiary lives
- There are two major TRICARE medical claims processors:
  - **Palmetto Government Benefits Administration (PGBA)** handles claims for the North and South regions
  - **Wisconsin Physicians Service (WPS)** handles claims for the West and Overseas regions, as well TRICARE for Life claims (regardless of stateside region)
- If a claim is sent to the wrong claims processor, the claim is either forwarded to the correct claim processing contractor or returned to either the provider or beneficiary

Who is Responsible for Filing the Claim?

- Beneficiaries are responsible for ensuring claims are submitted and processed, no matter who submits the actual claim
- If the beneficiary sees a network provider, the provider is responsible for filing the claim
- If the beneficiary sees a non-network provider, the provider can choose to participate or not:
  - Participating providers may submit claims for beneficiaries, but are not required
  - Non-participating providers are not required to file and may choose not to submit a claim on the beneficiary's behalf
  - Beneficiaries should ask their civilian providers if the provider will file the claim

Claim Filing

- A claim form should be submitted for each individual provider that rendered services
- A claim should be submitted for each family member regardless if they all visited the same provider on the same day
- Claims must be filed within one (1) year of the date of service or date of hospital discharge

Other Health Insurance

- If a beneficiary has Other Health Insurance (OHI), the beneficiary or the provider must file a claim with that health insurance plan before filing with TRICARE
- After the claim has been processed by the OHI, the claim can then be filed with TRICARE along with a copy of the other health plan's payment determination, and a list of itemized charges (bill)
- Beneficiaries should notify their regional contractor or the claims processing contractor about their OHI and any changes to it to avoid delays in claims processing or possible denials

Explanation of Benefits

- After submitting claims, the beneficiary and provider each receive an Explanation of Benefits (EOB) from the claims processor, showing the claim adjudication (settlement of payments) for the services performed
- Beneficiaries should carefully check each EOB they receive to compare their bills from the provider or service against the EOB
- Beneficiaries should contact their claims processing contractor if they are charged for a service they never received
- Beneficiaries should submit claims for any services received, but not submitted by their provider

Appeals

- To appeal means to request the regional contractor or TRICARE Management Activity (TMA) review an authorization or claims denial decision
- There are four types of appeals:
  - **Medical Necessity** - Based on whether the care is appropriate, reasonable, and adequate for the beneficiary's condition.
  - **Factual Determination** - Factual determination involve issues such as coverage, provider authorization (status) requests or denial of a provider's request for approval as a TRICARE provider
  - **Dual-eligible beneficiary (Medicare-TRICARE eligible beneficiaries)** - When Medicare and TRICARE have both denied a claim and the beneficiary has successfully appealed the Medicare claim (Medicare paid the claim), the beneficiary can appeal the TRICARE denial.
  - **Provider Sanction** - When a provider has been denied approval as an authorized TRICARE provider or who has been terminated, excluded, suspended, or otherwise sanctioned

What Can Be Appealed

- The facts of the beneficiary's case can be appealed including:
  - Diagnosis
  - Necessity to be an inpatient
  - Denial of preauthorization for services, including mental health
  - Termination of treatments or services that have been previously authorized
  - Denial of TRICARE payment for services or supplies received
  - Termination of TRICARE payment for continuation of services or supplies that were previously authorized
  - Denial of a provider's request for approval as a TRICARE-authorized provider or expelling a provider from TRICARE

What Cannot Be Appealed

- The amount of the TRICARE-determined costs or charges for a particular medical service
- The decision by TRICARE, or its contractors, to ask the beneficiary for more information before taking action on the beneficiary's claim or appeal request
- Beneficiaries cannot appeal decisions relating to the status of TRICARE providers
- Decisions relating to eligibility as a TRICARE beneficiary

Congratulations! You've Completed Module 13: Claims and Appeals

You should now be able to:

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- Describe how to resolve claims issues
- Distinguish between what can and cannot be appealed